



Medicare DMEPOS Competitive Bidding Problems

September 23, 2011

The Medicare Modernization Act of 2003 (MMA) required the Centers for Medicare and Medicaid Services (CMS) to replace the home medical equipment payment fee schedule for certain items with a 'competitive acquisition' or government contracting program. The bidding program was implemented on January 1, 2011 in nine cities across the U.S. and begins in an additional 91 metropolitan areas later this year. The first nine areas are Charlotte, Cincinnati, Cleveland, Dallas-Fort Worth, Kansas City, Miami, Orlando, Pittsburgh, and Riverside, California. The bid product categories are oxygen equipment and supplies, enteral nutrition, power wheelchairs, walkers, hospital beds, support surfaces and mail-order diabetic supplies. Any provider not awarded a contract is prohibited from providing bid Medicare items for the length of the contract, typically a three-year period.

CMS originally began implementation of the program in 2007. However, due to fundamental problems with the design of the program, Congress delayed implementation for a period of 18 months in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) so that CMS could correct those problems. In 2008, provider payment rates were reduced by 9.5 percent nationwide to pay for the bidding program delay. CMS has re-launched the program with minimal changes and ignored congressional intent, which was the basis for the initial delay.

The following are the most significant problems with the current bid system.

Problems with Current Bidding Structure

1. Bids must be Binding Commitments

- In Medicare's bidding program, bidders are not bound by their bids. Any contract winner can decline to sign a contract. This undermines the credibility of bids, and encourages low-ball bids from suppliers. Bids that are not accepted by contract winners are still included in Medicare's calculation of bid amounts.

2. Flawed Pricing Rule

- Rather than paying winners the clearing price (the last-accepted bid), Medicare's bidding program pays winners the unweighted median among the winning bids resulting in fifty percent of the winning bidders being offered a contract price *less than* their bids. This also means that half of the providers would reject the contract and the government would be left with insufficient supply. Other providers may accept the contract and cross-subsidize public patients with the revenue from private patients or take a loss.

3. Distorted Composite Bids

- A composite bid is an average of a bidder's bids across many products weighted by government estimated demand. Composite bids provide strong incentives to distort bids away from costs known as bid skewing. Bidders bid low on products where the government overestimated demand and high on products where the government underestimated demand. As a result, prices for individual products are not closely related to costs and providers participating in the program can "game" the system in order to manipulate the single payment amount.

4. Lack of Transparency

- Bids were accepted by CMS in November 2009, and now, August 2011, we still have very little information about how metrics for capacity and demand were calculated. This lack of transparency is unacceptable in a government contracting program.

5. No Due Process

- Currently, there are no due process protections or appeals processes in place for providers regarding the establishment of payment rates, the awarding of contracts, the designation of bidding areas, the phased-in implementation, the selection of items and services or the bidding structure and number of contractors.

6. Beneficiary/patient access to care and services is restricted

- Currently, through non-assigned claims, a patient may choose a provider that is either unwilling or unable to accept assignment for the needed products and services.
- Out-of-network claims are when health insurance carriers qualify a specific group of products and services to participate in-network. If the beneficiary chooses to go out-of-network, they may have to pay more up-front, pay more than the allowed amount and pay a larger percentage of the allowed amount.

Negative Impact of Bidding Implementation on Stakeholder Communities

1. Providers of Home Medical Equipment Services

- Providers are unable to provide products and services at Medicare's low single payment amounts.
- Some of Medicare's contracted providers either do not provide the products or services that they have been contracted to provide or furnish the wrong products and services.
- Qualified local providers were not awarded contracts to serve their own patients.
- Companies are going out of business and are terminating employee positions.
- Bankrupt providers and companies with credit problems were awarded contracts.
- Unlicensed providers were awarded contracts to provide products and services.

2. Patients

- Patients do not want to leave their trusted homecare providers or be forced to use unfamiliar companies that do not meet their medical needs and/or do not have the required products or services.
- As part of the referral process, access to products and quality service is restricted for patients who are customers of non-contract providers.

- Due to the complexity of repairs rules for contract providers, it is difficult for patients to obtain wheelchair equipment repairs.
- There is a broad range of products under each HCPCS code. In some cases, the least expensive product in a HCPCS code is being provided to patients, when that product may not be the best product to meet the patients' medical needs.

3. Hospital Discharge Planners/Nurses/Case Workers

- Discharge planners are delaying release of patients from hospitals because they cannot match patients to contracted provider companies with the appropriate products such as wheelchairs, oxygen equipment and supplies and sleep therapy devices. Patients not receiving suitable products and services can result in lowered compliance rates and increased medical costs.
- Discharge planners only send patients to home medical equipment providers who hold contracts for multiple product categories. Companies that have received Medicare contracts for one or two product categories are not being contacted by discharge planners.
- Discharge planners often have to use providers that are further away or outside of a competitive bidding area, which delays hospital discharges.

4. Physicians

- Some physicians have not received any information on who to contact for needed products and services.
- Physicians are unable to prescribe the required products for their patients.
- Physicians do not have access to accustomed provider services for patient training purposes under bidding.